SPECTRUM BEHAVIORAL HEALTH

POLICY HOLDER: ________________________ PATIENT NAME: __________________________

DATE OF BIRTH: __________________________

AUTHORIZATON FOR ASSIGNMENT OF BENEFITS

I authorize Spectrum Behavioral Health to apply for benefits from my insurance carrier and further authorize payment directly to me or to the party who accepts assignment of the healthcare/medical benefits, for services rendered by providers in Arundel Mental Health Professionals, LC., t/a Spectrum Behavioral Health.

YEAR	SIGNATURE OF RESPONSIBLE PARTY	DATE OF SIGNATURE

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of health/medical information required by my insurance carrier or its designated review agent, in order to determine benefits to which I may be entitled, or to designated agents of Spectrum Behavioral Health.

YEAR	SIGNATURE OF INDIVIDUAL, PARENT OR GUARDIAN	DATE OF SIGNATURE

MEDICARE PATEINTS ONLY

Beneficiary: _______________________________ ID Number: __________________

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Arundel Mental Health Professionals, L.C., T/a Spectrum Behavioral Health for all services furnished to me by my Physician/therapist. I authorize any holder of medical information about me to release to the Health care Financing Administration and its agents any information necessary to determine benefits or benefits payable for related services.

YEAR	SIGNATURE OF BENEFICIARY	DATE OF SIGNATURE

This entire authorization is valid for all episodes of care rendered by all providers associated with Spectrum Behavioral Health. I permit a copy of this authorization and agreement to be used in place of the original.